CHAPTER 1000

MEDICAL MANAGEMENT / UTILIZATION MANAGEMENT

1000 - CHAPTER OVERVIEW

REVISION DATES: 10/01/08, 11/01/05

INITIAL
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The standards and requirements included in this Chapter are applicable to AHCCCS Acute Care and ALTCS Contractors, the Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD), the ADES Comprehensive Medical and Dental Program (ADES/ CMDP), the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the ADHS Children's Rehabilitation Services (ADHS/CRS). If requirements of this Chapter conflict with specific contract language, the contract will take precedence. For purposes of this Chapter, the above listed organizations and agencies will be referred to as "Contractors".

At least annually, the Medical Management Unit (MMU) for Acute and Long Term Contractors or the Behavioral Health/Children's Rehabilitation Services Unit (Behavioral Health/CRS) for ADHS Contractors will conduct reviews of each Contractor's compliance with the requirements of this Chapter. MMU and Behavioral Health/CRS are units located within the Division of Health Care Management (DHCM).

The Chapter provides the necessary information to Contractors to ensure compliance with Federal, State and AHCCCS requirements related to medical management activities, including:

1. Utilization Data Analysis and Data Management
2. Concurrent Review
3. Prior Authorization
4. Retrospective Review
5. Adoption and Dissemination of Practice Guidelines
6. New Medical Technologies and New Uses of Existing Technologies
7. Case Management/Care Coordination

8. Disease/Chronic Care Management, and

9. Drug Utilization Review

DEFINITIONS

The words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning. Refer to Chapter 900 of this manual for other applicable definitions.

1. **Authorization Request (Standard)**, under 42 CFR 438.210, means a request for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest.

2. **Authorization Request (Expedited)**, under 42 CFR 438.210, means a request for which a provider indicates or a Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest.

3. **Concurrent Review** is the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. Contractor reviewers assess the appropriate use of resources, levels of care (LOCs) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.

4. **Disease Management** means an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

   a. Identifying and proactively monitoring high-risk populations

   b. Assisting members and providers in adhering to identified evidence-based guidelines

   c. Promoting care coordination

   d. Increasing and monitoring member self-management, and

   e. Optimizing member safety.

5. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. Grievances do not include "Action(s)" as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

6. **Medical management (MM)** means an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

7. **Retrospective Review** means the process of determining the medical necessity of a treatment/service post delivery of care.

8. **Utilization Management/Review** applies to a Contractor's process to evaluate and approve or deny health care services, procedures or settings based on medical necessity, appropriateness, efficacy and efficiency. Utilization review includes processes for prior authorization, concurrent review, retrospective review and case management.

Refer to:

- Chapter 500 for additional information regarding care coordination requirements
- Chapter 800 for Fee for Service (FFS) quality and utilization management, and
- Chapter 900 for member rights and responsibilities, medical records and communication of clinical information and additional related definitions.

REFERENCES

1. 42 CFR 438.200 *et seq* (Quality Assessment and Performance Improvement Including Health Information Systems)
2. 42 CFR Part 456, Subparts A through J (Utilization Control)
3. 42 CFR Part 164 (HIPAA Privacy Requirements)
4. Arizona Revised Statutes (A.R.S.) § 36-2903 (Duties of the Administration)
5. A.R.S. § 36-2917 (Review Committees)
6. Title 9 of the Arizona Administrative Code, Chapter 22 (9 A.A.C. 22), Article 5 (General Provisions and Standards)
7. 9 A.A.C. 22, Article 12 (General Provisions and Standards for Service Providers)
8. 9 A.A.C. 28, Article 5 (Program Contractor and Provider Standards)
9. 9 A.A.C. 28, Article 11 (General Provisions and Standards for Service Providers)
10. 9 A.A.C. 31, Article 5 (General Provisions and Standards)
11. 9 A.A.C. 31, Article 12 (General Provisions and Standards for Service Providers)
12. 9 A.A.C. 34 (Grievance System), and
13. AHCCCS Contracts.

1010 GENERAL REQUIREMENTS

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A. MM/UM PLAN

Contractors must develop a written MM/UM Plan that describes the Contractors' methodology to meet or exceed the standards and requirements of this Chapter. The MM/UM Plan, and any subsequent modifications, must be submitted to the MMU for Acute and Long Term Care Contractors, or to the Behavioral Health/CRS Unit for ADHS Contractors, for review and approval prior to implementation. At a minimum, the MM/UM Plan must describe, in detail, the following components of the Contractors' MM/UM program and how program activities will assure appropriate management of medical care service delivery for enrolled members. MM/UM Plan components must include:

1. A description of the Contractors' administrative structure for oversight of its MM/UM program as required by Policy 1010 C of this Chapter, including the role and responsibilities of:

   a. The governing or policy-making body

   b. The MM/UM committee

   c. The Contractor Executive Management, and

   d. MM/UM program staff.

2. An organizational chart that delineates the reporting channels for MM/UM activities and the relationship to the Contractor Medical Director and Executive Management

3. Documentation that the governing or policy-making body has reviewed and approved the Plan

4. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM/UM program functions and meet Contractor qualifications required by Policy 1010 C

5. The Contractor's specific MM/UM goals and measurable objectives as required by Policy 1020 of this Chapter

6. A work plan that addresses all requirements of this Chapter and supports the Contractor's MM/UM goals and objectives. Contractors must document how each of the following processes are implemented:

   a. Utilization data analysis and data management

   b. Concurrent review of acute levels of care

   c. Prior authorization (PA) (seven days per week, 24 hours per day)

   d. Retrospective review

   e. Adoption and dissemination of evidence-based and practice guidelines

   f. Evaluation of new medical technologies and new uses of existing technologies

   g. Case management/care coordination

   h. Disease/chronic care management, and

   i. Drug utilization review.

7. The Contractors' method(s) for monitoring and evaluating their service delivery system and provider network that demonstrates compliance with Policy 1020

8. A description of how delegated activities are integrated into the overall MM/UM program and the methodologies for oversight and accountability of all delegated functions, as required by Policy 1010 C, and

9. Documentation of input into the medical coverage policies from contracted or affiliated providers and members.

B. MM/UM EVALUATION

An annual evaluation of the effectiveness of the previous year's strategies and activities must be submitted as part of the MM/UM Plan, after being reviewed and approved by the Contractor's governing or policy-making body. The annual evaluation report must include, but is not limited to:

1. A summary of all MM/UM activities performed throughout the year with:
   a. The title/name of each activity
   b. The goal and/or objective(s) related to each activity
   c. Contractor departments or units and staff positions involved in the activities
   d. Statement describing whether or not the goals/objectives were met completely, partially or not at all, and
   e. Actions to be taken for improvement (Corrective Action Plan [CAP]).
2. Trends identified through MM/UM activities and resulting actions taken for improvement
3. Rationale for changes in the scope of the MM/UM Plan and program
4. Review, evaluation and approval by the MM/UM Committee of any changes to the MM/UM Plan, and
5. Necessary follow-up with targeted timelines for revisions made to the MM/UM Plan.

For submission to AHCCCS/DHCM, the MM/UM Plan and the MM/UM Evaluation may be combined or written separately, as long as required components are addressed and are easily located within the document(s) submitted.

Refer to Policy 1030 of this Chapter for reporting requirements and timelines.

C. MM/UM ADMINISTRATIVE OVERSIGHT

1. Contractors' MM/UM program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the MM/UM program. Contractors must ensure ongoing communication and collaboration between the MM/UM program and the other functional areas of the organization (e.g., quality management, member and provider services and grievances).

2. Contractors must have an identifiable and structured MM/UM Committee that is responsible for MM/UM functions and responsibilities, or if combined with the quality management committee, the agenda items and minutes must reflect that UM issues and topics are presented, discussed and acted upon.

   a. At a minimum, the membership must include:

      (1) The Medical Director as the chairperson of the committee (the Medical Director may designate the Associate Medical Director as his/her designee when the Medical Director is unable to attend the meeting)

      (2) The MM/UM Manager

      (3) Representation from the functional areas within the organization, and

      (4) Representation of contracted or affiliated providers.

   b. The Medical Director, as chairperson for the MM/UM Committee, or his/her designee, is responsible for the implementation of the MM/UM Plan, and must have substantial involvement in the assessment and improvement of MM/UM activities.

   c. The MM/UM Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or MM/UM Committee sign-in sheets with requirements noted).

   d. The frequency of committee meetings must be sufficient to demonstrate that the MM/UM committee monitors all findings and required actions. At a minimum, the Committee should meet on a quarterly basis.

e. The MM/UM Committee must review the MM/UM program objectives, policies and procedures annually at a minimum and modify or update them as necessary.

(1) The MM/UM Committee must develop procedures for MM/UM responsibilities and clearly document the processes for each MM/UM function/activity.

(2) The MM/UM Committee must develop and implement procedures to ensure that Contractor staff and providers are informed of the most current MM/UM requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community.

(3) The MM/UM committee must develop and implement procedures to ensure that providers are informed of information related to their performance (i.e., provider profiling data).

(4) The MM/UM policies and procedures, and any subsequent modifications to them, must be available upon request by AHCCCS/DHCM/MMU.

3. The MM/UM Program must be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in this Chapter in a timely and knowledgeable manner.

a. Staff qualifications for education, experience and training must be developed for each MM/UM position. The grievance process must be part of all new hire and annual staff training including, but not limited to:

(1) What constitutes a grievance,

(2) How to report a grievance, and

(3) The role of the Contractor's quality management staff in grievance resolution

b. A current organizational chart must be maintained to show reporting channels and responsibilities for the MM/UM program.

4. Contractors must maintain records that document MM/UM activities, and make the information available to AHCCCS/DHCM/MMU upon request. The required documentation must include, but is not limited to:

   a. Policies and procedures

   b. Reports

   c. Practice guidelines

   d. Standards for authorization decisions

   e. Work products resulting from clinical reviews (e.g. clinical concurrent review notes, PA reviewer notes)

   f. Meeting minutes including analyses, conclusions and actions required with completion dates if known

   g. Corrective action plans (CAPs) resulting from the evaluation of a component of the UM program such as inter-rater-reliability, and

   h. Other information and data deemed appropriate to support changes made to the scope of the MM/UM Plan and program.

5. Contractors must have written policies and procedures including, but not limited to, the following areas:

   a. Information/data received from providers is accurate, timely and complete

   b. Reported data is reviewed for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented

   c. All member and provider information protected by Federal and State law is kept confidential

   d. Contractor staff and providers are kept informed of at least the following to the degree that the information impacts the provider relationship with the Contractor staff:

      (1) MM/UM requirements, activities, updates or revisions

(2) Utilization data, and

(3) Profiling results.

e. Identification and subsequent necessary corrective action regarding over/under utilization of services

(1) Establishment of written criteria for evaluating the appropriateness and outcomes of services provided and ensuring that all staff involved in the utilization review have and utilize the written criteria in the same manner

(2) Development, implementation, monitoring, and reporting of over/underutilization of services to the MM/UM Committee, and

(3) Maintenance of records of the review of over/under utilization with the MM/UM committee meeting minutes.

f. Quarterly evaluations and trending of Contractor internal appeal overturn rates.

g. Quarterly evaluations of the timeliness of service request decisions.

h. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

6. Contractors must have in place processes which ensure that:

a. Health care professionals with appropriate clinical expertise render decisions to:

(1) Deny an authorization request, or

(2) Authorize a request in an amount, duration, or scope that is less than requested.

b. Health care professionals with appropriate clinical expertise, who have not been involved in any previous level of decision making, render decisions regarding:

(1) Grievances and appeals involving clinical issues, or

(2) Appeals involving denials based on medical necessity.

c. There is prompt notification to the requesting provider and the member or member's authorized representative or medical power of attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice must include information as specified in the ACOM, Policy 414 and 9 A.A.C. 34.

6.1 For purposes of section 1010 (C) (6) above:

a. The following health care professionals have the appropriate clinical expertise to render decisions for skilled and nonskilled medical services: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

b. In addition to those providers listed in 1010 (C) (6.1) (a), the following health care professionals have the appropriate clinical expertise to render decisions for nonskilled HCBS ALTCS medical services such as attendant care, personal care, homemaker, habilitation, and non-nursing respite care:

(1) Long term care case management staff with a minimum of three consecutive years of experience within the last five years in long term care when the individual is a:

(a) Registered nurse,

(b) Licensed practical nurse,

(c) Degreed social worker, or

(d) An individual with a bachelors or masters degree in a related field.

(2) Long term care case management staff with a minimum of five consecutive years of experience within the past five years in long term care when the individual does not have a degree or a license.

7. All Contractors must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM/UM Program. Data elements must include but is not limited to:

   a. Member demographics

   b. Provider characteristics

   c. Services provided to members, and

   d. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

8. Contractors must oversee and maintain accountability for all functions or responsibilities described in this Chapter that are delegated to other entities. Documentation must be kept on file, for AHCCCS review, and the documentation must demonstrate and confirm that the following requirements have been met for all delegated functions:

   a. A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity to the Contractor and must also include provisions for revocation of the delegation or include other remedies for inadequate performance.

   b. Contractors must evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation.

   c. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed by the Contractors annually, at a minimum.

   d. The following documentation must be kept on file and available for AHCCCS review:

      (1) Evaluation reports, and

      (2) CAPs, as necessary, to ensure quality for all delegated activities.

9. Contractors must ensure that:

   a. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services, and

   b. Providers are not prohibited from advocating on behalf of members within the service provision process.

1020 MM/UM SCOPE AND COMPONENTS

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A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

Contractors must have in effect mechanisms to detect both under utilization and over utilization of services (42 CFR 438.240(b)(3). Contractors must develop and implement a process to collect, monitor, analyze, evaluate and report the utilization data. On an ongoing basis, the MM/UM Committee must review and analyze the data, interpret the variances, review outcomes and develop or approve the interventions based on findings. Evaluation must include a review of the impact to both service quality and outcome. The MM/UM committee must determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address both over and under utilization of services must be integrated throughout the organization. All such strategies must have measurable outcomes that are reported in MM/UM minutes.

B. CONCURRENT REVIEW

Contractors must have policies, procedures, processes and criteria in place that govern the utilization of services in institutional settings. Contractors will have procedures for review of medical necessity prior to a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

1. Policies and procedures for the concurrent review process must:

    a. Specify the Contractor's role in managing members when the Contractor is not the primary payor. At a minimum, the Contractor must be a part of discharge planning.

    b. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information may include but is not limited to diagnosis, required services, diagnostic test results, and symptoms.

c. Specify timeframes and frequency for conducting concurrent review and decisions:

(1) Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed.

(2) Admission reviews should be conducted within one business day after notification is provided to the Contractor by the hospital or institution (this does not apply to precertifications) (42 CFR 456.125).

d. Provide a process for review that includes but is not limited to:

(1) Necessity of admission and appropriateness of the service setting

(2) Quality of care

(3) Length of stay

(4) Whether services meet the member needs

(5) Discharge needs, and

(6) Utilization pattern analysis.

e. Ensure consistent application of review criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in the concurrent review process. A plan of action must be included for staff who do not follow the criteria and timelines

f. Establish a method for the Contractor's participation in the discharge planning of all members in institutional settings

2. Criteria for decisions on coverage and medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

a. Medical criteria must be approved by the Contractor's MM/UM Committee. Criteria must be adopted from national standards. When providing concurrent review, the Contractor must compare the member's medical information against medical necessity criteria that describes the condition or service.

b. Initial institutional stays are based on the Contractor's adopted criteria, the member's specific condition, and the projected discharge date.

c. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay will be assigned a review date each time the review occurs. The Contractor ensures that each continued stay review date is recorded in the member's record.

C. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

Contractors must have Arizona licensed prior authorization staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the Contractor's medical criteria or make medical decisions.

Refer to Chapter 1600, Policy 1630, for qualifications of staff members who may authorize long term care home and community based services that are not considered skilled.

Refer to Chapter 300, Policy 310 for additional information regarding emergency services.

Contractors must develop and implement a system that includes policies and procedures, coverage criteria and processes for approval of covered services.

1. Policies and procedures for approval of specified services must:

   a. Identify and communicate to providers and members those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization must also be identified. Methods of communication with members include newsletters, Contractor website, and/ or member handbook. Methods of communication with providers include newsletters, Contractor website, and/ or provider manual. Changes in the coverage criteria must be communicated to members and providers 30 days prior to implementation of the change.

   b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers through the provider manual and Contractor website. Criteria must be available to members upon request.

c. Authorize services in a sufficient amount, duration or scope to achieve the purpose for which the services are furnished.

d. Specify timeframes for responding to requests for initial and continuous determinations for standard and expedited authorization requests as defined in Policy 1000, Definitions, and 42 CFR 438.210.

e. Provide for consultation with the requesting provider when appropriate.

f. Ensure consistent application of review criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in the prior authorization and service authorization review process. A plan of action must be included for staff who do not follow the criteria and timelines.

2. Criteria for decisions on coverage and medical necessity must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

a. Contractors may not arbitrarily deny or reduce the amount, duration or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member.

b. Contractors may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome, and

c. Contractors must have in place criteria to make decisions on coverage when the Contractor receives a request for service involving Medicare or other third party payers. The fact that the Contractor is the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes established by "1d" in this section. Refer to Policy 201, "Medicare Cost Sharing for Members in Medicare FFS", and Policy 202, "Medicare Cost Sharing for Members in Medicare HMO" in the AHCCCS Contractor Operations Manual for additional information regarding payment and cost sharing responsibilities. This manual is available from the AHCCCS Web site at www.ahcccs.state.az.us.

D. RETROSPECTIVE REVIEW

In instances where Contractors conduct medical necessity determinations post delivery of services, the Contractor must have in place policies, procedures, processes and criteria that govern how retrospective review will be conducted.

1. At a minimum, policies and procedures must:

   a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting the review. Qualified health care professionals involved in the Contractor's prior authorization process and/or concurrent review can not perform the retrospective review (second review) for the same service and member.

   b. Ensure consistent application of review criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of staff involved in the retrospective review process. A plan of action must be included for staff who do not follow the criteria and timelines.

   c. Describe services requiring retrospective review, and

   d. Specify time frame(s) for completion of the review.

2. Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence or a consensus or relevant health care professionals.

E. ADOPTION AND DISSEMINATION OF PRACTICE GUIDELINES

1. Contractors must develop or adopt and disseminate practice guidelines that:

   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field

   b. Have considered the needs of the Contractor's members

   c. Are adopted in consultation with contracting health care professionals and National Practice Standards, or

d. Are developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

e. Are disseminated by the Contractor to all affected providers and, upon the request, to members and potential members, and

f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply. (42 CFR 438.236)

2. Contractors must annually evaluate the Practice Guidelines through a MM/UM multi-disciplinary committee to determine if the guidelines remain applicable and represent the best practice standards and reflect current medical standards, and

3. Contractors will document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

F. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. Contractors must develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology from a systemic point of view as well as provisions for a case by case basis.

2. Contractors must include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

3. Contractors must evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. Contractors must establish:

   a. Coverage rules, practice guidelines, payment policies, policy and procedure and utilization management and oversight that allows for the individual member's medical needs to be met.

   b. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received.

G. CARE COORDINATION / CASE MANAGEMENT

Contractors must establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs, as defined by the Contractor. Coordination must ensure the provision of appropriate services in acute, home, chronic and alternative care settings that meet the member's needs in the most cost-effective manner available.

NOTE: ALTCS Contractors must also refer to the additional ALTCS Case Management Standards in Chapter 1600.

1. Contractors must establish policies and procedures that reflect integration of services to ensure continuity of care by:

   a. Allowing each member to select, or the Contractor to assign, a primary care practitioner (PCP) (or a clinician for an ADHS/DBHS member) who is formally designated as having primary responsibility for coordinating the member's overall health care

   b. Specifying under what circumstance services are coordinated by the Contractor, including the methods for coordination and specific documentation of these processes

   c. Coordinating covered services with community and social services that are generally available through contracting or non-contracting providers, in the Contractor service area

d. Establishing timely and confidential communication of clinical information among providers, as specified in Chapter 900, Policy 940. This includes the coordination of member care between PCPs and RBHA providers. At a minimum, the PCPs must communicate all known primary diagnoses, comorbidities, and changes in condition to the RBHA/RBHA providers when the PCPs become aware of the RBHA providers' involvement in care. The RBHA providers must provide pertinent diagnoses and changes in condition to PCPs in a timely manner. Contractors must facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange is occurring. The Contractor must initiate remediation in a timely manner when deficiencies exist.

e. Educating and communicating with PCPs who treat any member with diagnoses of depression, anxiety or ADHD that care requirements include but are not limited to :

(1) Expectations described in "d" of this section and

(2) Monitoring the member's condition to ensure timely return to the PCP's care for ongoing treatment, when appropriate, following stabilization by a RBHA.

2. Contractors must develop policies and implement procedures for members with special health care needs, as defined in Chapter 500, Policy 540 and Contract, including:

a. Identifying members with special health care needs

b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care need(s) or condition(s)

c. Ensuring adequate care coordination among providers, and

d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

3. Contractors must implement measures to ensure that members in Medical Case Management:

a. Are informed of particular health care conditions that require follow-up

b. Receive, as appropriate, training in self-care and other measures they may take to promote their own health, and

c. Are informed of their responsibility to comply with prescribed treatments or regimens.

4. Acute Care Contractors must have in place a Case Management process whose primary purpose is the application of clinical knowledge to coordinate member care needs for assigned members who are primarily medically complex and require intensive medical and psychosocial support. Case Management typically applies to members with catastrophic, chronic or multiple conditions that consume a disproportionate share of an organizations' health dollars.

   Contractors will develop member selection criteria for the Case Management Model to determine the availability of services, and work with the provider (as applicable). The Case Manager works with the PCP and or specialist to coordinate and address member needs in a timely manner. The case manager must continuously document interventions and changes in the plan of care.

5. The Case Management individualized care plan for either Acute Care or ALTCS members will focus on achieving member wellness (to the degree possible) and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager must also assist the member in identifying appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the member and the Contractor.

6. Contractors must provide oversight and monitoring of case management that is subcontracted or inclusive in a providers' contractual agreement. The case management role must comply with all AHCCCS requirements.

7. In addition to care coordination as specified in their contract with AHCCCS, the Contractor must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management as well as members who contact governmental entities for assistance, including AHCCCS.

8. Upon discharge from the Arizona State Hospital (AzSH), the Contractor must supply all insulin dependent diabetic members, with the same brand and model blood glucose monitoring device and supplies with which the member demonstrated competency while in the facility. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

   In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the Contractor must timely arrange ongoing medically necessary nursing services.

H. DISEASE/CHRONIC CARE MANAGEMENT

Contractors must implement a Disease/Chronic Care Management Program that focuses on members with high risk and/or chronic conditions that have the potential to benefit from a concerted intervention plan. The goal of the Disease/Chronic Care Management Program is to increase member self-management and improve practice patterns of providers thereby improving healthcare outcomes for members.

1. The Contractors' MM/UM Committee must focus on selected disease conditions based on utilization of services, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program.

2. The Disease Management Program must include, but is not limited to:

   a. Members at risk or already experiencing poor health outcomes due to their disease burden

   b. Interventions with specific programs that are founded on evidence based guidelines

   c. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members' ability to self-manage their disease and measurable outcomes

   d. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding of and adherence to the plan of care, and

e. Components for providers include, but are not limited to:

(1) Education regarding the specific evidenced based guidelines and desired outcomes driving the program

(2) Involvement in the implementation of the program

(3) Methodology for monitoring provider compliance with the guidelines, and

(4) Implementation of actions designed to bring the providers into compliance with the practice guidelines.

NOTE: The Contractor may adopt a nationally recognized Disease Management Program or develop its own.

I. DRUG UTILIZATION REVIEW

Drug utilization review (DUR) is a systematic, ongoing review of the prescribing, dispensing and use of medications. The purpose of DUR is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve member health status and quality of care.

Contractors must develop and implement a system, including policies and procedures, coverage criteria and processes for their DUR programs.

1. Criteria for decisions on coverage and medical necessity must be clearly documented and based on the scientific evidence and standards of practice that include, but are not limited to, peer-reviewed medical literature, outcomes research data, official compendia, or published practice guidelines developed by an evidence-based process.

2. Contractors must manage a DUR program that includes, but is not limited to:

a. Prospective review process for:

(1) All drugs prior to dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at a minimum, must be able to identify potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication and drug-age conflicts.

(2) All non-formulary drug requests

b. Concurrent drug therapy of selected members to assure positive health outcomes

c. Retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. The review process serves as a means of identifying and developing prospective standards and targeted interventions.

d. Pattern analyses that evaluates clinical appropriateness, over and underutilization, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications

e. Provision for education of prescribers and Contractor professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices and therapeutic outcomes. The program must include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.

1030 REPORTING REQUIREMENTS

REVISION DATES: 10/01/08, 11/01/05

INITIAL
EFFECTIVE DATE: 10/01/1994

Contractors must submit the following data reports as indicated:

REPORT	DUE DATE	REPORTS DIRECTED TO:
Quarterly Inpatient Hospital Showing Letter (Refer to #2 below)	15 days after the end of each quarter	Division of Health Care Management (DHCM), Medical Management Unit (MMU)
Utilization Management Plan and Evaluation	Annually, by December 15	DHCM/MMU
UM Quarterly Report	Quarterly, 60 calendar days after the end of the quarter	DHCM/MMU
HIV Specialty Provider List	Annually, by December 15	DHCM/MMU
Transplant Report	15 days after the end of each month	DHCM/MMU
Non-Transplant Catastrophic Reinsurance	Annually, within 30 days of the beginning of the contract year, enrollment to the plan, and when newly diagnosed	DHCM/MMU

NOTE:

1. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) must:

   - Refer to their AHCCCS Contract for due dates, and
   - Submit all reports to AHCCCS/DHCM/Behavioral Health Unit

2. The purpose of the Contractor inpatient hospital showing letter is to certify that:

   - A physician has certified to the necessity of inpatient hospital services
   - The services were periodically reviewed and evaluated by a physician
   - Each admission was reviewed or screened under a utilization review program and
   - All hospitalizations of members enrolled with AHCCCS health plans and program Contractors were reviewed and certified by their medical utilization staff.

3. If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the AHCCCS/DHCM/MMU, or, for ADHS/DBHS, a written request to the AHCCCS/DHCM/Behavioral Health Unit.